

that the closest nation to state medicine on a socialized form is Holland, where, however, there is no state intervention or even state law regulating the insurance funds of organized physicians and druggists. Almost every Hollander belongs to some mutual insurance fund.

#### *German and English Systems*

"In Germany, the sickness insurance companies come under a certain amount of governmental administrative and judicial powers. The state does not contribute anything to the funds.

"In Denmark, according to Doctor Corwin, 'without compulsion, the state feels that it is its duty to provide hospital facilities for the entire population. Nearly all of the Danish physicians practice as salaried employees of the municipalities.'

"England, as early as 1912, established the so-called 'panel system.' Health insurance is made compulsory, and all insurance funds of the lower-salaried classes are administered by the crown. Choice of doctors is permitted, although in the service dispensed confinements and some other medical services are not included.

"Sweden, which approximates Denmark in its state medicine, incidentally has the best hospitals in the world, declares Doctor Corwin.

"Therefore, it will be seen that other than in Soviet Russia, state medicine, strictly speaking, does not exist. Surveys made show that in many European countries the care of the sick is below that of our own communities.

#### *Hospital Care Here*

"The American Medical Association provides statistics showing that in the United States, 63.8 per cent of the 955,869 hospital beds are Government owned, i. e., either by the nation, states, county or city. The American Medical Association, in citing the advancement of Federal and state owned hospitals, believes that 'one may view it as a preparatory step in a civic duty in the matter of chronic cases where family financial support fails; or may view it as a preparatory step in a policy of unlimited expansion whose ultimate goal is state medicine.'

"Doctor Parran believes that as traditional forms of medical practice are abandoned it will be wise to look to the program that the British have set up.

"If, through evolution or revolution, we find ourselves to the extreme left and part of a socialist state tomorrow,' he says, 'then we doctors, too, will be socialists. Or, if we are not, our successors will be. State medicine will exist in the sense that the state will operate medical and health services in a manner comparable to our present system of public education.' The medical recommendations contained in the platform of the British Labor Party give at least a rough idea of what that would be like. Or, if we recognize obvious differences in the level of medicine here and in Russia at the beginning of the World War, we may find some suggestions in the medical organization of that country."

## THE LURE OF MEDICAL HISTORY\*

### THE TUBERCULOSIS MOVEMENT IN CALIFORNIA†

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#### I

FOR nearly a century the control of tuberculosis has been a major problem in this state. On the twenty-second of April, 1934, sixty-four years elapsed since the California State Board of Health held its first meeting. Only one year before that, the first state board of health in the nation was formed in Massachusetts. The California Tuberculosis Association is in its thirty-fourth year. The Bureau of Tuberculosis of the State Board of Health, one of the first formed in the country, will soon be twenty years old. It is fitting, therefore, from time to time to cast up our accounts, audit them, chalk up our successes and failures, and chart our future course. Let us first examine our assets with care, that we may take the utmost advantage of them.

#### I. SOME 1934 ASSETS

*An Enlightened Medical Profession.*—In California, as in most communities, the medical profession has taken the lead in the battle against tuberculosis. There are men here today who took a leading part in the early medical discussions concerning tuberculosis in this state. There are others, but one generation removed, whose wisdom and foresight in planning and directing this movement was prophetic. In 1871, Dr. Henry Gibbons, then president of the California State Board of Health, stated that doubtless a great number dying here of tuberculosis had brought the *germs* of the disease with them. This, eleven years before Koch's announcement!

True to the conservative traditions of medicine, these men and their successors have acted slowly, exchanging opinions, gathering data, and studying the problem from all angles. Once these medical leaders had decided what was best to do, their determination was equal to their earlier conservatism. Largely as a result of their initiative, under the sponsorship of a special State Tuberculosis Commission, the county sanatorium subsidy bill was finally passed and the State Bureau of Tuberculosis was created in 1915.

The California Tuberculosis Commission came into being through an act passed by the California Legislature. Its report (State Printing Office File, No. 13387) was compiled by its Executive Committee, consisting of Dr. George H. Kress, Los Angeles, chairman; Dr. Charles C. Browning, Los

\*A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of CALIFORNIA AND WESTERN MEDICINE. The column is one of the regular features of the Miscellany Department of CALIFORNIA AND WESTERN MEDICINE, and its page number will be found on the front cover index.

† From the division of the Pacific Coast Welfare Division, Metropolitan Life Insurance Company, San Francisco.

‡ Presented at the annual meeting of the California Tuberculosis Association at Fresno, April 6, 1934.

Angeles; Dr. R. G. Broderick, Oakland; Mr. A. Bonnheim, Sacramento; Miss Katherine C. Felton, San Francisco; and Dr. William F. Snow, State Health Director, Sacramento. Mr. Guy P. Jones of the state health office at Sacramento acted as secretary.

That body went on record as being in favor of county and district rather than state sanatoria; of giving a state subsidy to the county sanatoria when maintained in accordance with standards laid down by the proposed bureau of tuberculosis of the California State Board of Health. These three recommendations of county sanatoria, state subsidy, and a state bureau of tuberculosis, were the direct and almost immediate results of the recommendations of the Executive Committee of the California Tuberculosis Commission. The passing years have shown the wisdom of those recommendations. The system then inaugurated by California has since been copied by other states.

Physicians were largely, one might say, entirely, responsible, too, for the formation of the California Tuberculosis Association (the original name being California Association for the Study and Prevention of Tuberculosis); and it is significant that today they take an active and interested part in guiding its affairs. I dwell on this at some length in order to impress the fact that in this, as in most public health movements, the medical leaders of the state have taken an active part. Certainly this medical participation remains today the first of our tangible assets.

*An Enlightened Public.*—Mr. Higby announces that, in this fourth year of our greatest depression, the California Tuberculosis Association will report the third highest amount collected through seal sales of any state in the country. According to estimates, New York State collected last year 5.5 cents per capita; Pennsylvania, 3.6 cents; and California, 3.3. The national average for last year was 2.4 cents per capita. This is incontrovertible evidence of the enlightenment of a public whose knowledge has been gained in large part from their medical advisers, and whose enthusiasm and untiring efforts have been fostered from year to year by the challenge in the task of preventing unnecessary illness and death. The entire picture of tuberculosis control in California is permeated with a happy relationship between a studious, scientific, conservative, and generous medical profession and an educated, energetic, persistent, and generous public. This is no mean item in our list of assets.

#### UNEXCELLED SANATORIUM SYSTEM

Since 1915, ninety per cent of the population of this state have gradually acquired access to tax-supported county sanatoria for the treatment of tuberculosis. But this is only half the story. These sanatoria are among the best in the country, thanks in large part to the system of state subsidy, the state subsidy being one of the major recommendations of the California Tuberculosis Commission. See above. In order to qualify for state support, they must meet certain mini-

mum standards. In the biennium, 1915-1916, the state expended \$75,000 for subsidy and support of local county tuberculosis sanatoria. This amount increased each year until 1931-1932, when it was \$1,136,000. It is significant that, even last year, the amount appropriated by the state for this purpose was \$993,040. From 1915, through 1933, a total of \$5,184,000 has been appropriated by the state to assist in the medical care and rehabilitation of its tuberculous.

This state now has 5,218 beds for tuberculous patients distributed among twenty-eight public sanatoria, and thirty private and semiprivate institutions. This is exclusive of United States Government hospitals. This comes close to the Framingham standard of one bed per death. Deaths in California in 1932 were 5,027.

The significance of this system can scarcely be overestimated. In addition to restoring thousands of our citizens to health and normal lives, it has made each of these an object lesson to his friends on the advantages of modern tuberculosis prevention measures. Another result has been the development within the state, or the attraction to the state, of a group of specialists in tuberculosis treatment and control, who are second to none in the nation. These men have had a profound influence upon their medical colleagues, on the one hand, who are kept currently informed concerning the newer methods of diagnosis, treatment and control, and their lay colleagues, on the other hand, who have ready access to sound advice concerning the direction of this public health movement.

#### LOCAL TUBERCULOSIS ASSOCIATIONS

Partly as a result of the preceding three items of assets, we now have in this state, under the banner of the California Tuberculosis Association, sixty-two local associations, of which fifty-nine are entitled to official delegates in the state body. Fourteen of these associations have adequate full-time personnel, with excellent programs and skilled workers under the immediate direction of a combined lay and medical board.

Herein lies an enormous state-wide influence, the full implications of which have probably never been appreciated by any of us. First, this Association forms an important link in the nationwide chain of tuberculosis safeguards. Second, it spreads throughout the state an infusion of public health consciousness. It directs public opinion to a more complete realization of the importance of public hygiene. It supports and encourages official health departments and the health activities of schools. Thus, an antituberculosis program at the same time points the way to a complete public health program. It influences legislation and political appointments. It seizes upon and puts into local use each new procedure for public health improvement which has been tested and found successful elsewhere. It elaborates its own successes, and passes them on for use by others.

Although this Association is a great power, its influence has been but gently felt in this state. It is one which may develop to guide and promote

the entire state public health policy. It could be used to an even greater extent than at present to protect local and state public health activities from political interference, to facilitate an ever greater participation of the medical profession in public health activities, to teach the wisdom that an ounce of prevention is worth a pound of cure when considering public health appropriations, to safeguard the poverty-stricken health officer, often struggling single-handed against inadequate appropriations and insufficient public support, and, finally, to pursue its present conquest to its logical and rightful conclusion: the eradication of tuberculosis as a major cause of death.

There are many other assets rightfully ours, the contemplation of which gives us well-deserved satisfaction. It is a poor business concern which does not take full advantage of all its assets. May these assets of ours never grow less, and may we, as time goes on, appreciate them and use them more completely.

(To be continued)

## CLINICAL NOTES AND CASE REPORTS

### PNEUMONIA COMPLICATING PREGNANCY AND LABOR

WITH BRONCHOPNEUMONIA IN THE NEWBORN

By LINDSAY PETERS, M. D.  
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#### REPORT OF CASE

MRS. W., twenty-eight years, white, housewife.  
*Family History.*—No hereditary disease.

*Personal History.*—Tonsillectomy twenty years ago; scarlet fever, 1926. Menstruation began at eleven years; every twenty-eight days; duration five days, moderate amount; severe pain first four hours. Married on June 24, 1931. No children. No miscarriages. Last menstruation, May 29, 1933. Expected date of confinement, March 7, 1934. Some nausea first two months. No vomiting. Except transient albuminuria, corrected by diet, the pregnancy was uncomplicated.

On March 2, 1934, about 7:30 p. m., the patient telephoned that she had had a sore throat for some days past, and she felt that the cold was going into her chest. I advised that she remain in bed and take tablets of sal ethyl carbonate, grains 5. When I saw her next morning, I learned that immediately after telephoning me the previous evening, she had a hard chill, lasting an hour, and that in spite of the sedatives I prescribed, and aspirin in addition, she spent a restless night on account of fever and pain in the left side of the chest. Her temperature was found to be 101.5 degrees Fahrenheit, pulse about 100, and she still had intense pain in the left side of the chest, but I was unable to detect signs of pneumonia or pleurisy. The chest was strapped with adhesive plaster, and two peralga tablets were given. This was followed by two hours of sleep, and when I saw her again about 12:30 p. m., her temperature was normal, pulse about 100. She then informed me that since 11 a. m. she had been having uterine contractions. This was confirmed by abdominal palpation, and rectal examination showed the cervical canal obliterated, the degree of dilatation of the external os undetermined and the head de-

scended to mid-pelvic position. She was then sent to the Alameda Sanatorium, where she arrived about 1:30 p. m.

*Physical Examination.*—Teeth, good. Tonsils, removed. Cervical glands not palpable. Thyroid not enlarged. Nipples small and cupped. Heart normal. Left side of chest strapped for pain. Chest not examined on admission.

Fundus uteri, three finger-breadths below ensiform. Firm contractions at three-minute intervals. Head engaged. Small parts to right, dorsal plane to left, fetal heart low in left lower quadrant. Position, L. O. I. A.

Pelvic measurements: Sp. 26.5; cr. 28.25; tr. 31.5; bisisch. 10.5; diag. cong. undetermined, on account of inability to reach sacral promontory.

Rectal examination about 3:15 p. m. showed head low in the pelvis, but the degree of dilatation uncertain; therefore the patient was taken to the delivery room and carefully prepared for vaginal examination, which showed complete dilatation, the head almost down to the perineum; hence the membranes were ruptured with scissors. Escaping amniotic fluid contained an unusually large amount of meconium. Fetal heart sounds, heard at frequent intervals by Doctor Jackemy, were said to be good. At 3:30 p. m., for analgesia, sodium amytal, grains 9, by mouth, followed at 4:30 p. m., by scopolamin, grain 1/100, intramuscularly. Immediately after rupturing the membranes, pudendal anesthesia was produced by injection of 40 cubic centimeters 1-1000 solution of nupercain.

The head promptly came down on the perineum and began to separate the labia during contractions, but expulsive efforts were impaired by pain in the chest and, in view of the possibility of serious lung complications, low (outlet) forceps were applied without additional anesthesia; after mediolateral episiotomy the head was easily lifted over the perineum and delivery completed without difficulty at 5:18 p. m. Pituitrin, one cubic centimeter, was then given intramuscularly and after repair of the episiotomy, the placenta was expressed with some difficulty and fluid extract of ergot, dram 1, immediately given by mouth. There was little loss of blood, and the placenta and membranes appeared to be complete.

After the patient was returned to bed, restlessness and confusion, due to sodium amytal and scopolamin, continued most of the first night and cough was troublesome. Next morning, in spite of having had only about one and one-half hours of sleep, the patient was in good spirits, but examination of the chest revealed unmistakable signs of consolidation at the base of the left lung, posteriorly.

On account of the seriousness of the complication, Dr. Fletcher Taylor was asked to see her in consultation and made the following recommendations: At least 3000 cubic centimeters fluids, containing 2000 calories daily, with addition of salt. For pain, amidopyrin with amytal and codein, grain one-half. Enemas to be given with Y-tube. Watch urine and leukocyte count; oxygen tent; continue diathermy.

Sputum was sent to the laboratory the first day after delivery, but no pneumococci could be isolated, only a nonhemolytic streptococcus and *Staphylococcus albus* being found.

The third day after delivery, a blood culture was made, and seven days later it showed a pure culture of nonhemolytic streptococcus. The only other laboratory reports of interest were the blood counts, showing a surprising degree of anemia and a rather low leukocyte count.

There was a rapid extension of the pneumonic process upward in the left lung, and on the third day postpartum crepitant râles were heard at the right base. The next day, both lobes of the right lung and the left, upper lobe showed bronchial breathing; coincident with this was a clearing up of the original focus at the left base.

The fatal termination on the fifth day, postpartum was preceded by wild delirium, ending in coma.